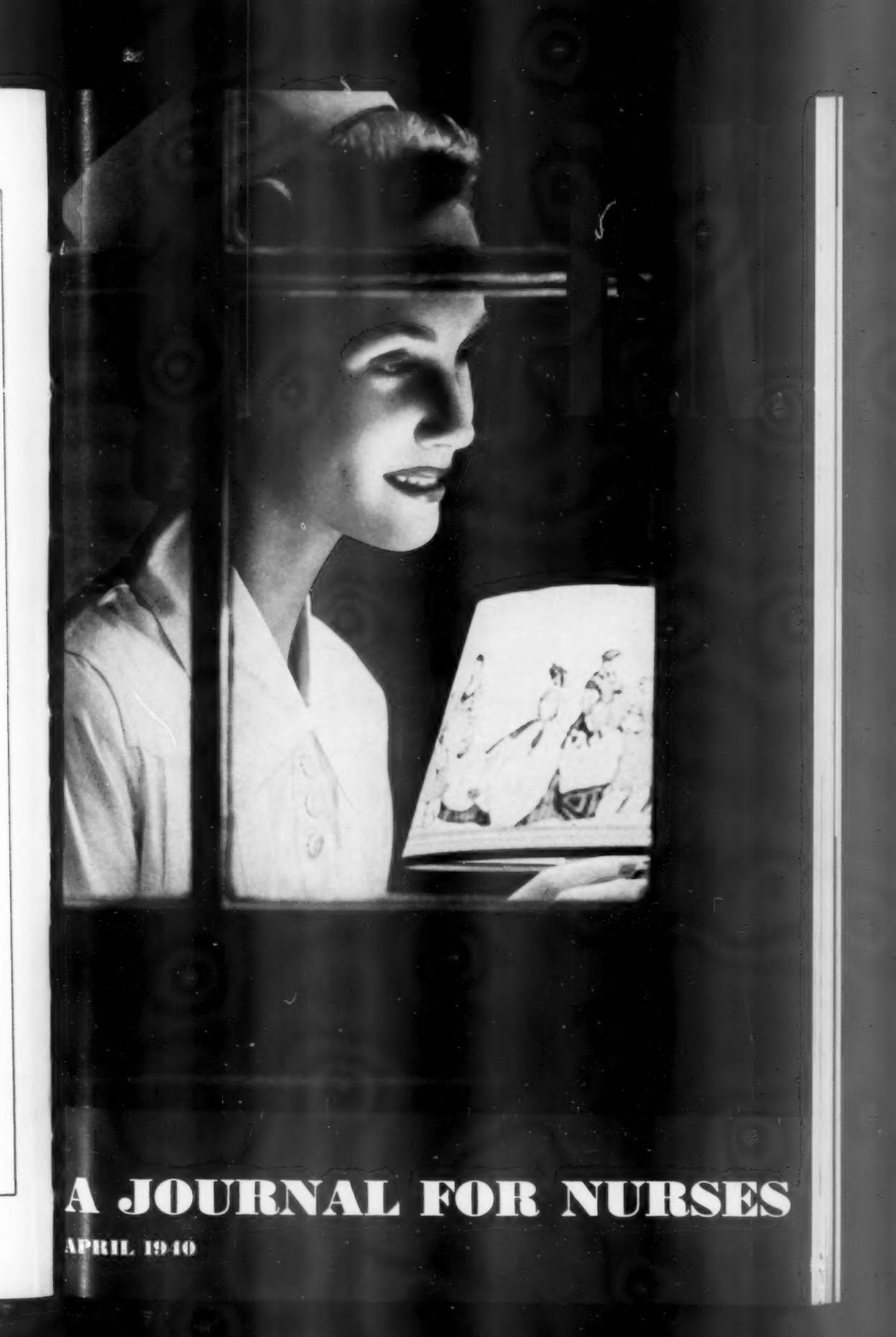

A JOURNAL FOR NURSES

APRIL 1940

REDUCE HEALING TIME in Impetigo Contagiosa

with Wyeth's ALULOTION AMMONIATED MERCURY *with* KAOLIN

Controlled clinical tests have shown that the healing time in Impetigo Contagiosa was reduced from an average of 26.9 days to 15.0 days when Wyeth's Alulotion Ammoniated Mercury with Kaolin was used on the impetigo lesions instead of the frequently employed ammoniated mercury ointment.* Your doctor will be interested in these facts.

MAIL the attached card for clinical sample.

*Jrl. Med. Soc. New Jersey, **36**, 442 (July) 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

IN *This* ISSUE

April 1940 Vol. 3, No. 7

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A JOURNAL RN FOR NURSES

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Debits AND CREDITS

FREE PRESS

Dear Editor:

In the February issue comes your editorial about the nurse who thinks "they" should not be fed such a strong diet. The lady is naive. Why is she any more able to think straight than the rest of us? An uncensored press is America's proudest boast . . .

As for unions, joining the A.F. of L. or the C.I.O. is like surf-board riding. Once we're hooked, we get taken for a ride, and have mighty little to say about the direction . . .

However, it's an interesting subject to discuss, and I admire nurses who have the courage to tackle it.

Mary Buchanan-Thomas, R.N.
Elaine, Ark.

SWEETNESS AND LIGHT?

Dear Editor:

I've been receiving R.N. for a year or so, and really get a kick out of it . . .

But—"Less Sweetness and Light" rubbed me the wrong way in several spots. If Mrs. Brande wanted a fair point in describing a nurse, why did she go to fiction? As a writer, she should know that fiction isn't based on facts . . .

I do agree that red finger nails, perfume, endearing talk, and the weight of decisions, should be kept from the sick-room. I think that most nurses are conscious of this. We are always willing to please, if patients will mention their likes and dislikes.

R.N., Casper, Wyo.

Dear Editor:

I can think of nothing more harrowing than putting on a gray or faun-colored uniform; going on duty in a sick-room where the sunshine is barred; and having Dorothea Brande for a patient.

R.N., Shreveport, La.

Dear Editor:

I enjoyed Dorothea Brande—and oh how true! I, for one, am certainly going to watch my step in the future.

Of course I enjoyed the other articles too. Each new copy of R.N. which I receive becomes as beautifully dog-eared as its predecessor.

R.N., Jamaica Plain, Mass.

[*For a nurse's reply to Dorothea Brande's article, see page* 14.—THE EDITORS.]

ORCHID

Dear Editor:

Congratulations on the January issue. The editorial "Folly to be Wise" is a fine bit of common sense. Arthur Geiger's article on legislation prompts me to ask if we can't hear more from him.

We nurses sorely need leaders who are courageous enough to face our economic problems, our long hours of work, our hospital food situation. We need help in getting together for the improvement of our living conditions.

Your magazine is a step in that direction. Here's to your success.

Sarah Dickstein, R.N.
New York, N.Y.

BARGAINS

Dear Editor:

In response to the interesting letter from Grace Wilkins in January, I, for one, am much in favor of eight-hour duty. But how can we get it?

If we refuse any but eight-hour calls, all those other calls will go to less qualified people and we will be the losers. Some registries will send out practical and undergraduate nurses to serve as graduates, and the public has no way of knowing what it is getting.

The only way to get straight eight-hour duty is to suppress the demand for twelve-hour duty. The latter is kept alive because it saves the patient $2 in comparison with the price of three eight-hour nurses.

We should raise the price of twelve-hour duty up to or above the price for three eight-hour nurses. Then no one would consider two tired twelve-hour

nurses a bargain when he could have three fresh eight-hour ones for less money. I was told by the registry once, when I objected to twelve-hour duty, that as long as patients demanded it the registry had to supply nurses who would do it.

K. Rottger, R.N.
Royal Oak, Mich.

[*In most cities, private nurses receive $5 a day for eight-hour duty, $8 for twelve hours. Thus, a good selling point for eight-hour nursing is the fact that the patient actually saves by engaging three nurses for eight hours each. Do private nurses keep doctors and patients informed on such matters?*—THE EDITORS]

OPINIONS WANTED

Dear Editor:

I would like to hear from some of the registered nurses in California who have competitive Civil Service. Do they like it, or not?

C. Keefe, R.N.
New York, N.Y.

SUPPORT

Dear Editor:

If we paid the A.N.A. the amounts of money which labor unions ask, nurses' organizations would have more staff members and more lobbyists in Congress. But the A.N.A. should be given credit and support for what it has done thus far.

I have gone through strikes, and have been employed by a union in a non-nursing capacity. I can say for myself and my co-workers that we never experienced anything so degrading. We will never forget the incidents we witnessed and experienced. They left us with a distaste for union methods, especially in professional fields.

If we want anything, let's fight for it through the A.N.A.

Antoinette Drew, R.N.
Lyndhurst, O.

PROTECTION

Dear Editor:

I read with interest your article about nurses' unions. To my way of thinking, it's a splendid idea! At least nurses won't get kicked about from one place to the other, without any reason. The union at least protects its members, although the fee is sometimes high.

I have worked in Los Angeles hospitals for over a year, and have been taken off the payroll for no apparent reason. The unions would investigate such treatment. I can get work with smaller sanitoria—12-hour duty, no hours off, for $50, $60, or $70 a month. That is no living wage!

Hospitals hire their own nurses first; outside nurses don't have a chance. Every time I get laid off I pay $33.50 for another job through an agency.

Nurses are not organized. All they do is talk among themselves. When it comes to a showdown, they are afraid to give their opinions for fear of losing their jobs.

Why don't we get together, and protect the general-duty nurse?

R. Darling, R.N.
Los Angeles, Calif.

EXPANSION

Dear Editor:

Regarding your recent article and correspondence on labor unions for nurses, I thought your readers would be interest-

Stale perspiration odors account for a part of sick room odor. Smart nurses know that personal "air-conditioning"* of their patients (and themselves) with MUM neutralizes stale perspiration odors. Patients often feel better mentally and are thankful for the new freshness of the atmosphere.

MUM

Takes the Odor Out of Stale Perspiration.

— Does Not Interfere with Normal Sweat Gland Activity

2 Big Tips—MUM on sanitary pads says sh-sh-sh-sh. Applied to hot, perspiring feet, MUM cools, soothes and deodorizes.

A Boxful of Freshness

A dab of soothing MUM, applied to underarms and other skin areas, maintains personal freshness by banishing stale perspiration odors. Quick, non-irritant; does not stain clothing or bed linens.

*Personal "air-conditioning" as herein used applies to the removal of stale perspiration body odors which occasionally permeate an office or room.

BRISTOL-MYERS COMPANY, 19-D W. 50th ST. NEW YORK, N. Y.

ed to know that the American Federation of Labor unit in New York City has been advertising in The New York Daily News for practical-nurse members.

How can they call themselves the American Federation of *Registered* Nurses and, at the same time, solicit membership among the unfit and untrained?

R.N., New York, N.Y.

[*The ad to which this reader refers advised practical nurses that they must secure a license to practice in New York State by July 1, 1940, under the new nurse practice act. Practical nurses were urged to communicate with the American Federation of Registered Nurses for "further information." No direct appeal for practical-nurse membership was made. Authoritative nursing sources in New York City, however, advise that both A.F. of L. and C.I.O. groups plan to extend their membership to subsidiary workers.*—THE EDITORS]

UNION

Dear Editor:

Nurses so often argue: "If we join a union we will be reduced to the level of maids, porters, and janitors." The majority of laymen place us in this category now. They are unable to discriminate between the R.N., who has studied three years or more, and the p.n. who puts on a full uniform and works along with us.

The irony of this situation is that many hospitals hiring practical nurses are operated by registered nurses. This certainly proves lack of unity. The p.n. should be restricted to simple bedside care in the home only. Proper supervision of registries is needed to give us protection...

We wouldn't need the help of unions if we would just get together!

Ethel Peterson, R.N.
Seattle, Wash.

[R.N. *believes many nurses may disagree with the statement regarding public attitude toward professional nursing. However, Miss Peterson's plea that nurses "get together" echoes the sentiment of most of the readers who commented on the labor story.*—THE EDITORS]

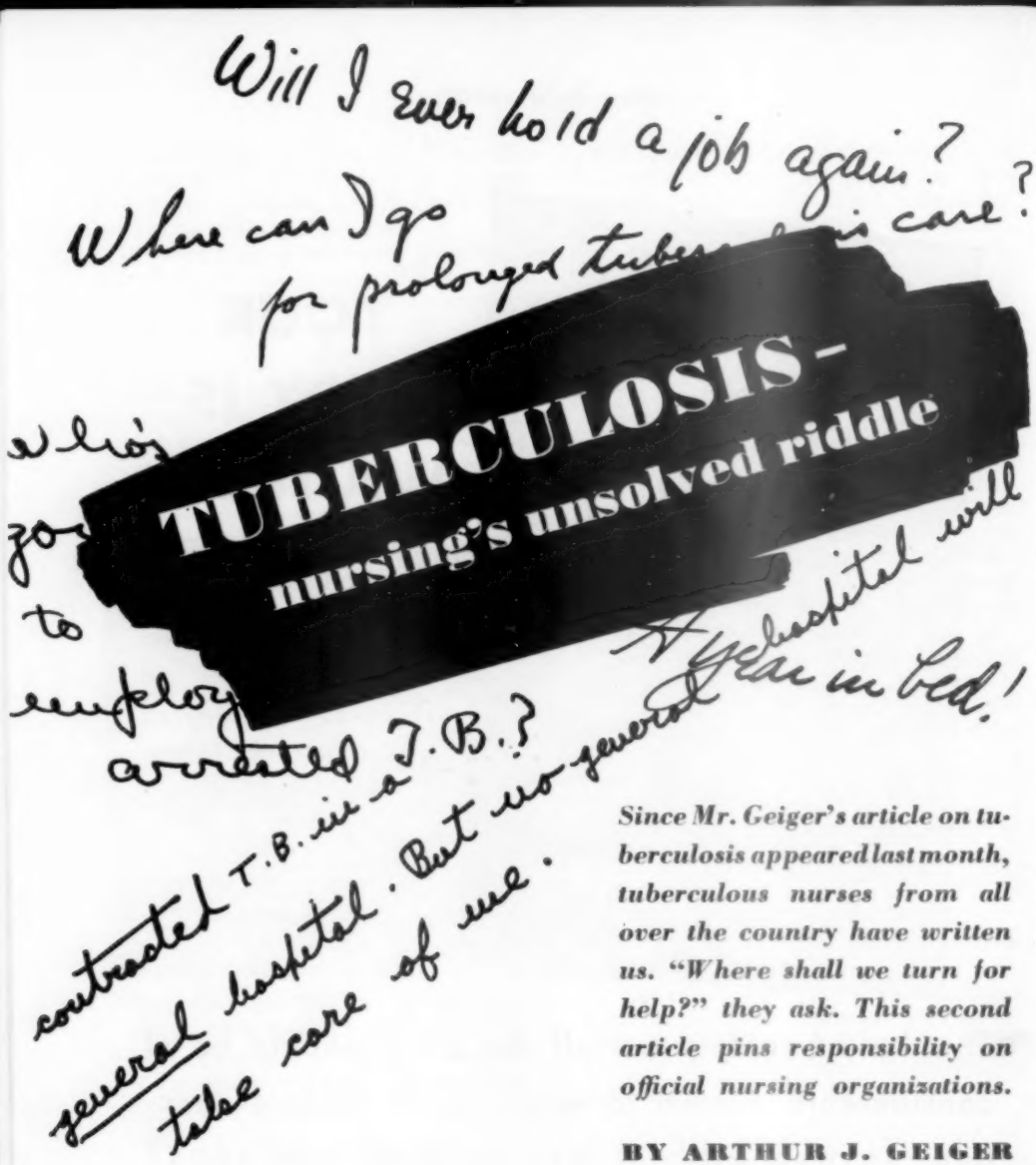
BUDGET

Dear Editor:

I have a system much like Miss Carter's ("Budget for Better Living," January issue). I use envelopes too, and with great success.

When I'm paid each month, I divide the amount into separate envelopes for each item. I've arranged things so that alumnae dues come out of the January pay check; glasses are charged to February, auto tags to March, dentist bill to April, and so on through the year. I've never been broke yet!

Helen Eder, R.N.
Upper Darby, Pa.



Since Mr. Geiger's article on tuberculosis appeared last month, tuberculous nurses from all over the country have written us. "Where shall we turn for help?" they ask. This second article pins responsibility on official nursing organizations.

BY ARTHUR J. GEIGER

● Over half the nurses discharged from tuberculosis sanatoria are "incompletely cured."

This is not just a statement made to create a dramatic effect. It is the conclusion arrived at by sound medical authorities after long and careful investigation. Findings show that many so-called "cured" nurses break down when they resume professional life. Some try to carry on while still, unknowingly, in a contagious stage—a menace to themselves, their associates, and their patients.

Can these nurses be said to have been given a full chance for recovery?

"Yes," says official nursing opinion. Ignoring the nurse's abnormally high incidence—a third higher than among women of the same age in the general population—leaders fail to see that nurses are entitled to "special privileges" in regard to treatment. As one executive expressed it:

"No nurse need ever go without attention. Her hospital will take care of her. If she is a graduate of Chicago's Michael Reese Hospital, for instance, Boston's Massachusetts General, Philadelphia's Pennsylvania Hospital, or New York's Presbyterian, all she has to do is ask for a bed. They'll see that she gets it."

This question was then asked:

"But suppose she *isn't* a graduate of one of these fine institutions. Suppose her hospital has no provision for cases of her kind?"

"Oh, you are just making up hypothetical cases," came the reply.

Inquiries at representative hospitals with endowed beds for tuberculous nurses, moreover, disclose strings often attached to the available hospitality. The beds are usually few in number. They may be occupied. The candidate may, for one reason or another, be unacceptable. Or, if she is accepted, care is normally for a short period only.

The same general principles apply to free sanatorium beds for nurses.

No matter where the tuberculous nurse turns for care, she meets similar "ifs."

She may coax a grant or loan out of her alumnae, providing she is in good standing and they have anything to give. Her co-workers may hold a "benefit" for her, although the proceeds from such affairs are rarely sufficient to finance extensive treatment. Or if she has been in army or navy service, she may be able to enter a Federal hospital.

One resource to which nursing leaders point with pride is the relief funds maintained by the State associations.

Some of these, like that of the Illinois State Nurses' Association, offer financial aid to stricken members. Others have no provision for help of this sort. Still others, such as the Massachusetts State association, have no fixed policy governing distribution of sick funds. They handle each case "on an individual basis."

Nearly all State associations are chary about divulging the extent of their assistance. But because their funds are necessarily limited and are mainly intended for "general relief," the amount available to tuberculous nurses is thought to be negligible.

Tuberculosis has been proclaimed an "occupational disease" by a number of authorities. Therefore, it would appear logical that nurses could expect State aid under the Workmen's Compensation Laws. The loophole is that it is *legally* recognized as such by only one State—New York.

Even there, the benefits are hemmed in by all kinds of clauses. The claimant's hospital must be of a certain type. It must have a certain number of employees in various classifications. And the nurse's illness must be traceable to her employment—which may be difficult to prove.

Because of the "red tape" involved, compensation officials suspect that not all nurses who are entitled to government aid take advantage of it. The only way to determine eligibility is to apply for it.

Nevertheless, the awards are quite liberal. The maximum for total disability is $25 a week for the rest of the patient's life. These payments normally continue "for the duration of the disease"; ceasing upon re-employment. Their size depends upon the "extent of disability and the applicant's former average weekly wage."

Outside New York, the prospect of State assistance is not very bright. A number of States, the National Council on Compensation Insurance reveals, have ruled tuberculosis a "personal disease" for nurses; hence, not compensable. Others refuse to recognize that "occupational diseases" call for compensation.

Another possibility is that the nurse might insure herself against tuberculosis.

Some public-health nurses have been

able to do this through group policies taken out by their employers. But the individual nurse is pretty much out in the cold, so far as insurance is concerned. A specialist in this field—the head of the health insurance department of one of the nation's largest underwriters—explained why.

"We'd be saps to insure nurses," he said, "when you consider their morbidity and mortality rates. So far as I know, no conservative carrier offers a policy with tuberculosis benefits to women—to say nothing of nurses."

Tuberculosis authorities agree that, of all the groups within the profession, the private-duty nurse is the least protected.

If she has been out of training any time at all, they say, she has probably lost contact with her alumnae. She cannot place responsibility on any hospital, since she is her own employer. She is ineligible for compensation in the one State that provides it. She is exempt from the usual group insurance, as she isn't attached to any group. And the moment she stops working, her income stops.

Private-duty nurses who were interviewed on this question back up the opinion of Dr. Kendall Emerson, of the National Tuberculosis Association. He maintains that "private-duty nurses are the ones who really need protection. An appeal to their State nursing associations would help in solving their problems."

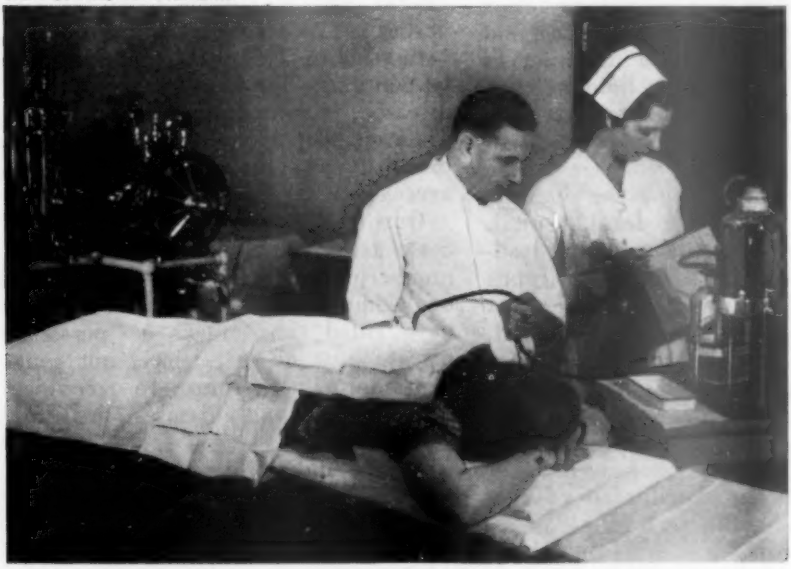
●

The foregoing comprises nursing's tuberculosis riddle. As to where the solution lies, there are as yet only individual answers.

Some contend that nursing should have its own sanatorium, as have a number of other professions. They claim that it is only fair that the public should contribute toward the support of those who have fallen in its service. [*Continued on page* 40]

★ *Collapse therapy is now recommended treatment for many T.B. cases. Yet few nurses have access to free pneumothorax. Many are too proud to apply to clinics for care.*

Courtesy, Stonywold Foundation



UNDERSTANDING THE *Blind*

You needn't be nursing the blind to find inspiration in this story. The author is that remarkable blind woman whose recent autobiography has brought courage to thousands.

BY ALICE BRETZ

● "You're blind."

That was a difficult thing for my doctor to say. A difficult thing for any human to have to pass on to another, more terrifying in some ways than the words "you're going to die." Yet, it was true: I was blind; I would never see again.

I lay very still and finally the doctor and nurse left me alone. There was something horrible in my hospital room at that moment. It crouched evilly close to my face, ready to touch me if I moved. I didn't dare put up my hand. The hopeless struggle was like a nightmare. Only this wasn't a dream. It was real. It would last for the rest of my life.

Horror of the years of darkness ahead develops in everyone who hears for the first time that he is never to see again. Whether or not the fear takes root and grows to a frenzy, however, may depend entirely on the understanding attitudes of those who are closest to the patient when he learns he is blind.

And that places a tremendous responsibility upon the nurse. For it is she to whom the patient instinctively turns in this loneliest moment of his life.

My first night of knowing blackness, for example, might have been far more frightening than it was had it not been for my nurse. She knew that I was awake and every now and then gave me a cigarette. At last she asked me if I had ever heard of miracles. She spoke gently of miracles she had seen, and of others which she believed. I listened. These were physical miracles. And somehow my mind was turned from my personal despair to realization of a greater truth.

It's true, of course, that the nurse is helpless to alleviate the immediate mental agony of blindness. But she can certainly shorten its duration.

Consider the patient's family. Everyone feels sorry for them and they in turn are helplessly sorry for the afflicted one. So much pity is unhealthy and soon forces the patient to feel overly sorry for himself. Now if the nurse could say to the members of the family, "How wonderful your mother's attitude is. She's a marvel of courage. You must be proud!" the nurse would be in the happy position of substituting appreciation for pity. The effect is obvious. Immediately the son or daughter beams and replies, "She *is* wonderful. I *am* proud." This is excellent therapy for the ego of everyone concerned. Just that small amount of appreciation gives the blind person the sense of making something of his life. He feels less of a burden to his family. The family begins to forget its hopelessness in re-

gard to the patient's condition. Already, the period of constructive readjustment has begun.

There are many types of emotional reactions to blindness. But the sit-down strike is, perhaps, the most prevalent among the adult blind. I know a woman who lost her sight two years ago and has done nothing but cry ever since. Nothing interests her; nothing amuses; nothing penetrates the thick armor she wears against life. She simply will not budge from her position of protest against Fate.

If you have a patient like this one, don't give her up as hopeless. Use all the knowledge of human nature at your command to help bring her across the barrier. For if someone is not able to do this for her, her future will be lonely indeed. Friends and family do not want to be with a person who makes her blindness too hard for them to bear.

In your work with the recently blind, begin by encouraging the patient to do things for himself. The guiding hand is not always needed.

Take feeding, for instance. From the very start, if the patient is able, urge him to try to feed himself. You will, of course, cut up his meat and butter his bread, and tell him where dishes and silver are placed on his bed-table. But he'll gain needed confidence fast if he realizes he doesn't have to be fed like a child.

At several eye hospitals the nurses have worked out an interesting system of "eating around the clock." When food is brought to a patient, he is told, "Steak is at 9 o'clock, spinach at 12:00, potatoes at 3:00, carrots at 5:00 etc.", according to the location of food on his plate. This method may save the patient the embarrassment of groping around his plate for his food.

Here are a few little things you can watch for to help simplify mealtime: Avoid using a tray instead of a table when your patient is able to sit up. Trays held in the lap are too far away from the mouth; food inevitably gets lost on the way. Don't let the diet-kitchen send up a half-grapefruit as a "special treat"—unless they take it out of the shell first. (Nothing develops a frustration faster than trying to eat grapefruit in the dark!) Urge your patient to explore gently with his fingers the location of glasses and cups; otherwise they are bound to be upset.

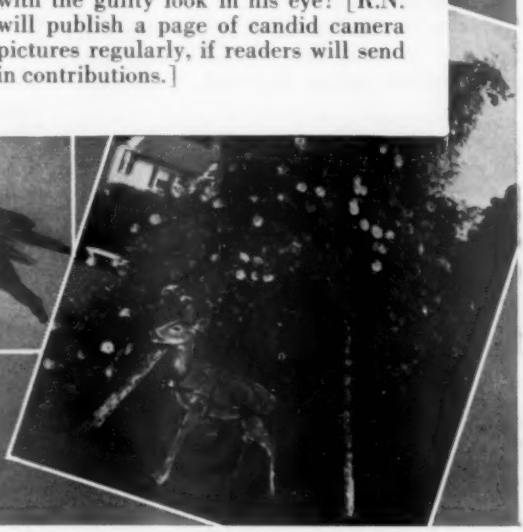
Next to eating, dressing is the biggest problem of the newly blind. You can help by saying, "This is your blue satin dressing gown." "This is your gray wool dress," and so on, as you assist your patient in dressing. Thus, the texture of the fabric and the lines of the gown will become identified in the patient's mind; when she goes home she will have a basic pattern already established for selecting the clothes she will wear each day.

The same technique is advisable when helping the patient into her clothes. "This is the right armhole." "Now I am going to put on your right shoe." Automatically, the patient puts out her right arm or foot—making the dressing procedure much easier for both of you.

I recounted this in a talk before a group of nurses once and added that a blind person should always be spoken to before being touched. I urged them, for instance, to say "Here is a clean handkerchief. I'll put it in your right hand." I went on to say that if someone touched my hand without speaking I'd jump. Even a normal person is startled by something unexpected which brushes against him in the dark.

When I had finished the lecture and got ready to leave, I had an agreeable surprise. A soft voice said, "Here is your coat, and this is the right sleeve." I was charmed. It was my first experience with being helped into my coat efficiently and graciously.

Walking, by the way, is a considerable problem to the recently blind patient. Especially the first few days he is able to be [*Continued on page* 24]



NURSES' Pets

● Nurses *aren't* too busy for pets, as these snapshots from R.N. readers show. Upper left, Vera Winget of Salt Lake City, Utah, talks things over with her pet squirrel. Below are Iva Williams of Bakersfield, Calif., and her lamb; and in Sodus, N.Y., Elizabeth Charters with Midnight, the talkative crow... Pete the tame deer was orphaned in a motor accident near Stanhope, N.J. Now he is Helen Shaw's star boarder... R.N.'s own mascot is Bingo, the pup with the guilty look in his eye! [R.N. will publish a page of candid camera pictures regularly, if readers will send in contributions.]

"Dear Mrs. Brande—"

ELIZABETH M. BERMAN, R.N.

● Dear Dorothea Brande:

So you think we're too cheerful, too starched; too brisk, too bustling. ["Less Sweetness and Light, Please" R.N., February]. Now isn't there another side to the question too? Will you listen to the nurse's point-of-view as patiently as we listened to yours?

Anybody who has nursed for any length of time knows there is no general formula for behavior on duty. Why? Simply because no two patients ever react in exactly the same fashion. The characteristics which may annoy you, may go down in the next room and the next as the makings of another Florence Nightingale. "Cheerful briskness" and "starched efficiency" may actually be tonics for Mrs. Jones across the corridor. She would, in fact, describe anything less as "droopy indifference," or "slovenly incompetence."

Haven't you heard? It's this very difference in attitudes of individual patients which makes the work of the special nurse one of the most difficult and trying jobs in the world.

"When I entered his room, I became the ministering angel."

I remember standing, one day, at the window of a hospital diet kitchen, chuckling. I was not inflating my ego when I said to myself, "The world lost a great character actress, my gal, when you chose nursing as a profession."

I was thinking of three patients in adjoining rooms. Mr. Arthur was an intelligent, elderly gentleman—but difficult and fractious. The moment I entered his room I became coldly professional, pleasant but dignified. "Good morning," would have been redundant—a nod sufficed . . . He said I had good sense and he wished there were more nurses like me. Would I please irrigate his incision before I went off duty? He couldn't stand that fluttery Miss Davis working on him.

Next door was Mr. Barrett. He was a 230-pound male who looked like something left over from the days of the Neanderthal Man. Flat on his back, he whined. When I entered *his* room I became the ministering angel. I didn't say "dearie," and I didn't talk baby talk. But I was on the verge of it. I was so sweet and solicitous I almost sickened my own stomach . . . He thought I was wonderful. He said to believe him, he didn't want any of those hard-boiled unsympathetic nurses around him. He was *ill*, and they'd better get that through their heads.

Then there was Mrs. Carter. She was 38, socially prominent, and had an insatiable appetite for amusement. To her I was the hospital's four-star comedienne. I was a riot. She couldn't make up her mind whether I was most like

"The ring of the telephone still gives rise to suspense and dread . . ."

Fanny Brice or Bea Lillie. But anyway, I was a scream. She didn't know what she'd do without me.

Well. There you are, Mrs. Brande. Three different personalities. No one pattern, you see, can possibly be adequate. Forgive me—but could you change *your* personality as often as the private nurse must in the course of any year?

When two normal healthy people meet in social intercourse, there is always an unconscious attempt on the part of each to adjust himself to some extent. Each attempts to please, to make himself agreeable, to win approval. With two people trying, it's fairly easy to establish some sort of rapport.

"To Mrs. Carter I was the hospital's four-star comedienne . . ."

But in nurse-patient relationships, the personality adjustment is one-sided. It's almost entirely the job of the nurse because the patient's capacity to respond is temporarily depleted. Sickness, pain, consequent mental depression have made normal response impossible. Instead of two people dividing the load, the nurse must carry it alone.

Graduate nurses who have been in private duty as long as twenty years say that the ring of the telephone when they are on call still gives them the same moment of suspense and dread they experienced the first year out of training. Why? you may ask. Why not elation instead of frenzy?

I think I can tell you why. The problem of adjusting to a new personality, of exploring the great "what now?". Not what illness. Not, "Will it be an appendectomy, pneumonia, or fracture?" These are all routine. But what sort of a *person*. What's going to be expected of me in the next hour, the Duchess of Windsor, Mae West, or Elsie Dinsmore?

It's impossible to relegate all patients to the same category and label them "Sick People." Every one is an individual with different habits, background, and convictions. Sickness does not reduce them all to [*Continued on page* 38]

The T.B. threat

• Tuberculosis, according to medical authority, is the most widespread of all infectious diseases. It thrives on overwork, fatigue, inadequate nutrition, and other factors which lower systemic resistance. Long and repeated exposure to the tubercle bacillus may also cause tuberculosis—even in the absence of other predisposing conditions.

Nurses offer a fertile field for the inroads of this disease. They work too hard and too long when employed. They worry too much and eat too little when unemployed. Almost any day any nurse may have some contact with T.B. For even in general hospitals, research shows, a great many patients have some tubercular infection.

In the light of these incriminating circumstances, tuberculosis is rapidly becoming nursing's "unofficial" occupational disease. Its status is unofficial because, as Mr. Geiger says in an article in this issue, organized nursing is not ready to admit that tuberculosis threatens nurses more than women in other professions. This, despite the unusually high incidence shown by medical and statistical research.

We believe a more realistic attitude is needed, and a sound, carefully worked out plan to provide care for those nurses who succumb and need financial aid.

At the present time there is no national program for sick relief for ailing nurses. The A.N.A.'s relief fund was turned

over to the various State nurses' associations almost ten years ago. But, with few exceptions, no adequate local plans have yet developed.

While this decentralization of responsibility was undoubtedly justified, according to the way nursing organizations are set up, a "decentralization of interest" can never be justified.

It is the responsibility of any parent organization to establish policies and to assist its various branches to push these policies into action. It would be no task for a national association to coordinate relief funds throughout the States. Nor difficult to guide each State in developing a sick relief quota—especially for T.B. care—proportionate to the size of that State's membership. It would not be difficult. . .and it would give each State needed incentive for keeping relief programs alive.

The A.N.A. could do this job expertly, for it is not without experience as a fund coordinator. During the past year, for instance, it has guided individual States toward raising their share of the $90,000 Florence Nightingale International Foundation pledge.

There is no reason why the same amount of interest and help from the A.N.A. could not do as much for a program of local care for tuberculous nurses. Let us hope, therefore, that A.N.A. members will ask their professional association to take this step before too many more nurses fall ill with tuberculosis.

ACCENT *on* Spring

BY MONA HULL, R.N.

Here's a glimpse of the new uniform styles to be featured this season. Models 1 *and* 2 *are sharkskin. Models* 3, 4, *and* 5 *are poplin. Notice the interesting use of diagonal and patch pockets and tucks.*

● "Imagination" is the uniform by-word for Spring. Designers tell us that nurses, casting a newly critical eye on the work-clothes question, demand a 1940 slant on traditional standards.

The nurse is no longer content to shut her eyes and snatch the first good-quality poplin that comes along. Today, she picks her uniforms as she does her personal wardrobe: for style, comfort, wearability, and that indefinable personal "wallop."

Proof that nursing has come out of the "It's only a uniform" stage is to be found in R.N.'s newest survey of readers' uniform interests. Here are some of the points readers raised:

"Haven't we been in a rut about uniforms, buying them habitually, like toothpaste . . .?"

"Why prolong our prim, starched-like-a-board, turn-of-the-century atmosphere . . .?"

"Can't we combine modern style and comfort with the professional appearance . . .?"

"Of course you can," was the response of uniform designers, who created their new Spring lines to fit nurses' demands. The result is a new freedom in style, a wide variety in material, and adequate "wallop" to make new nurses of us all.

Style and fabric are the twin stars which continue to guide nurses on buying expeditions. (Survey figures show that the two factors are equally potent.) The uniform manufacturers are, therefore, offering a wider than usual vari-

ety of styles and materials this Spring. These are available for every pocketbook. So when you select your Spring and Summer wardrobe you can let your personal choice reign supreme.

It is interesting to recall that not very long ago there were only a few uniform fabrics to choose from. Similarly, all uniforms had the same characteristic straight, almost military, lines. This year, however, stylists have more than ever before adapted the uniform to the season's new silhouette: the squared-off shoulders, the long torso, and the flared skirt.

It is obvious that the old-time stiff fabrics would not lend themselves to such a feminine outline. Hence, old fabrics have been improved and soft new fabrics added—materials which have never before been used in uniform manufacture.

In R.N.'s survey, readers voted poplin the "First Fabric" of the year. With this in mind, some manufacturers hint that for these [*Continued on page* 34]

Acute INTESTINAL OBSTRUCTIONS

• Disruption of the continuity of the gastrointestinal tract promptly produces the symptom complex of ileus or intestinal obstruction. The obstructing lesion or process may be situated anywhere along the duodenum, jejunum, ileum, or colon. Generally speaking, lesions closer to the stomach produce the more severe types of intestinal obstruction.

Ileus may be roughly divided into two large groups:

1. The paralytic type. This is due to paralysis or atonicity of a portion of the intestinal tube.

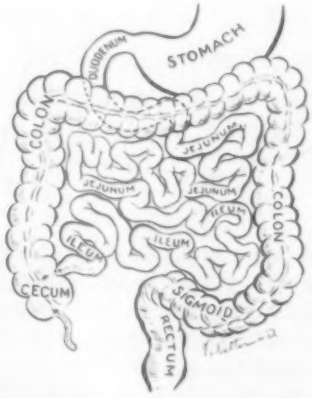
2. Mechanical ileus. This may be produced in one of two ways—by an organic lesion which mechanically interferes with the propulsion of the intestinal contents, or by a process that cuts off the blood supply to a portion of the intestine, resulting in gangrene of the involved segment.

Paralytic ileus.—This form of intestinal obstruction always accompanies diffuse peritonitis. It is caused by the deleterious influence of the bacterial infection upon the muscular activity of the bowel wall. Paralytic ileus may develop after gastrointestinal operations, and is frequently associated with biliary or renal colic. Twisting of an ovarian cyst may be followed by paralytic ileus.

The condition develops quickly. Severe abdominal distention, nausea, persistent vomiting, and constipation are the essential features. At first consisting of gastric contents, the vomitus becomes bile tinged and later yellow or green-yellow in color. In low obstruction it may become fecal in character. The vomitus in paralytic ileus is watery and of large quantity, indicating regurgitation into the stomach of fluids from low in the intestinal tube.

In contradistinction to beginning peritonitis, paralytic ileus produces a soft and distended abdomen; the abdominal wall in the former condition is rigid and scaphoid. As ileus develops in diffuse peritonitis, distention takes the place of rigidity. If untreated, paralytic ileus—especially post-operative—threatens the life of the patient.

Treatment, if instituted early, is usually promptly effective. By means of the gastric or nasal tube, the stomach is



Above: Obstructions occur along the duodenum, jejunum, ileum, or colon. Opposite: Treatment must include improvement of patient's general condition, and relief of the obstruction. Here are three methods. L. to r.: Preparation for venoclysis; enterostomy drainage; gastric lavage.

emptied of fluid and gas. Periodic suction or continuous suction thereafter by means of the Wangensteen technic usually maintains a state of gastric and intestinal decompression. Fluids by mouth are withheld. Saline and dextrose solutions are given intravenously to make up for the loss occasioned by the persistent emesis. Some physicians administer drugs to stimulate intestinal peristalsis. Associated conditions responsibile for the ileus are treated in the indicated manner.

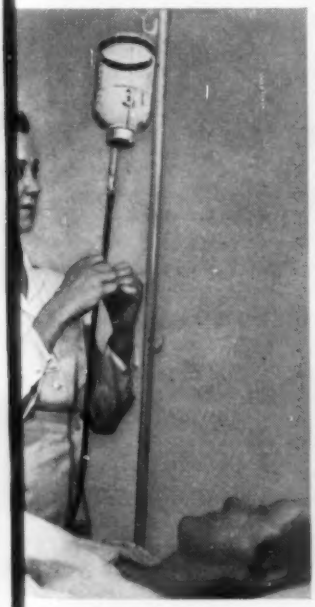
Types of mechanical obstruction.—There are many causes of mechanical obstruction of the bowel. Polyps and carcinoma masses within the lumen may grow to the point where they no longer permit propulsion of intestinal contents. Adhesions and scars of previous operations, if properly situated, by slow contraction may "pinch off" the bowel lumen. Large gallstones, too, have caused intestinal obstruction. Tumors of neighboring organs, growing adjacent to and compressing the intestines, may lead to ileus.

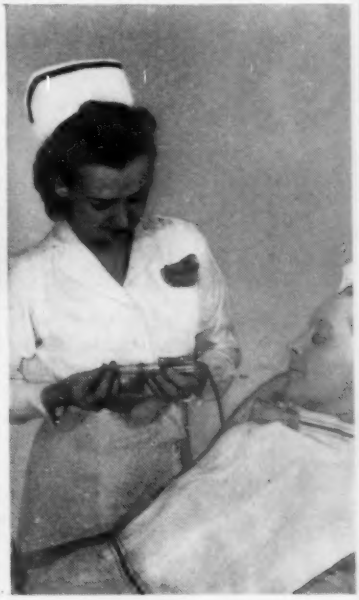
One special group of conditions produces severe obstruction with strangulation. The blood supply of the involved intestine is interfered with, creating the possibility of local gangrene if prompt surgical measures are not promptly undertaken. These conditions are: (a) volvulus, or twisting of the bowel on its long axis; (b) intussusception, telescoping of one portion of the bowel into another; (c) strangulated hernia, or herniation of a segment of bowel through an opening which stops the blood supply and which is so small as to prevent return of the bowel to the abdominal cavity. Contracting adhesions produce strangulation by constriction of the intestinal arteries.

The location of the lesion determines to a large extent the severity and the nature of the symptoms produced. Carcinomas of the colon or sigmoid may produce only severe constipation with little or no vomiting. Obstruction in the jejunum leads to frequent vomiting and rapid collapse.

Symptomatology.—Pain is the most significant and characteristic symptom. It appears intermittently and is

Leigh





cramp-like in nature. Mild at first, it becomes so severe as to make the patient cry out with discomfort. The wave then recedes and the abdomen is quiet again until the next paroxysm develops.

Vomiting is a prominent feature. The expelled material quickly becomes bile colored and is often fecal in odor. Projectile vomiting is seen in neglected cases. At times, when the stomach is empty, unsuccessful vomiting attempts make the patient extremely miserable.

Constipation is complete; neither feces nor gas is expelled, even with the aid of enemas.

The abdomen is soft at first, later becoming distended. Failure to institute proper therapy may lead to peritonitis and elevation of the temperature which, as a rule, is normal in simple obstruction. Abdominal tenderness is elicited only if the causative lesion is strangulating in character.

Various types of obstructing processes produce their own distinctive characteristics. Volvulus occurs in middle-aged adults who usually give a history of chronic constipation. The process occurs most frequently in the sigmoid, producing tenderness in the lower left quadrant of the abdomen.

Intussusception occurs most often in children. Usually sudden in onset, it produces sharp colicky pains. Bloody stools are passed for a day or two. A sausage-like mass can usually be palpated in the abdomen. The most common site for intussusception to occur is at the junction of the ileum and cecum. Hence, the point of greatest tenderness is at the lower right quadrant. The most common [*Continued on page 30*]

Wide World

Off to WAR AREA

● "We're proud to be the first to go!" says Delphine Wilde, head nurse for the American Scandinavian Field Hospital Unit.

The Unit (shown here with Herbert Hoover) sailed late last month for Finland to do emergency and rehabilitation work. With it went six ambulances, eighty beds, X-ray and surgical equipment, and nine tons of canned food. The staff will work at least six months in devasted areas under the direct command of the Finnish Army.

Nursing equipment includes sleeping bags, rubber boots, ski outfits, flashlights, and kerosene stoves. Uniforms are a gray-green twill, decorated with Hospital Unit insignia in Finnish blue and white. Outfits include jackets, two skirts, ski pants, two shirts, and a trench coat with removable lining. Cosmetics go along too—to keep up morale!

NUTRITION Briefs

● No wonder the pleasantly-plump person complains he must climb a mountain in order to lose a pound! Sometimes, he moans, fat seems as immovable as the mountain. And it may be, because fat literally is only a "*storehouse* of energy," not a direct fuel. It probably isn't oxi-

dised during muscular activity, as is generally believed. Instead, it hangs on until the last speck of carbohydrate is burned by the body. Even then the fat doesn't go to work directly. It has to be converted, first, into carbohydrate before the muscles can use it.

All this is offered as a possible—and probable—conclusion to a series of complicated tortures performed on some long-suffering rats who were starved, fed, prodded into activity, operated on, and fed some more. The expected result—fat oxidation in the muscles—didn't materialize. Instead, the fat content of the exercised and the rested muscles remained the same, though the carbohydrate content of stimulated muscles decreased notably.

Here is further evidence for those experiments showing that workers get along better on high carbohydrate than on high fat diets. It also explains why Katinka could push trolleys all her life and still remain hefty as long as she liked her chocolate creams!—*Gemmille, C. L.: Effect of Stimulation on Fat and Carbohydrate Content of the Gastrocnemius Muscle in Phlorizinized Rats. Bull. Johns Hopkins Hosp. February 1940.*

● Far to the South lie islands of succulent fruits waiting to be discovered anew by the individual who's allergic to foods. For these tropical foods, imported from the West Indies to Florida, may well prove to be the much-needed substitutes for those persons who are hypersensitive to our commonest foods.

The natives of those isles, where generations have experimented with the foods, know best how to prepare them. A trip to Jamaica yields many delightful recipes for those who must cater to the allergic's limited taste. For those who can't eat wheat flour, welcome substitutes might be cassava flour, used in griddle cakes, puddings, and other dishes, though the cassava root is used here almost exclusively to make tapioca. Or the romantic breadfruit, which when sliced, roasted, and ground into flour tastes "like batter pudding." Taro, widely used in Hawaii as a substitute for potatoes, is known in Jamaica as coco, and is something like a yam. The person who can't eat grapefruit or oranges may choose instead papayas, star-apples, and best of all, the naseberry, which "tastes like pear and has the consistency of applesauce." Just

the exotic names should prove tempting and exciting to the individual who has not been looking forward to his proposed rations of goat's milk and soy beans!—*Vaughan, W. T.: Introduction to Tropical Foods. Jour. Amer. Dietet. Assoc. February 1940.*

The blind

[*Continued from page* 12]

up and around the hospital. Encourage him to get up and move about with you as his guide just as soon as he is well enough to do so. If he attempts to find his way from bed to chair alone, warn him to feel his way about with his hands —which can stand a few bumps much better than his nose can.

The sightless simply cannot stride out like normal people. But it took me quite a while to learn that. Especially since I had made up my mind that I would learn how to walk around a room alone. Without a friendly hand to guide me, my usual swinging step brought my forward foot into sharp contact with a piece of furniture. The result was invariably a bruised instep, ankle, or shin. My step had to be shortened and my feet raised only high enough to skim the rug.

When you walk with a patient, go slowly. Let him take your *right* arm and keep just a half-step ahead of him. Suggest to him that he touch things along the way. In the hospital, for instance, he can run his fingers along the bed-table, the dresser, the chair in his own room. And, if you take him into a private sitting-room or lounge he can touch tables, lamps, bookshelves, or perhaps a piano or desk. A blind person likes to identify the objects around him, for when he does he feels not quite so lost in the pea-soup fog. He recognizes what normal people take for granted: that he is not moving in a void, that there are other people and things all around him.

Most blind people are very sensitive to sound. The banging of doors, rattling of dishes or water pitchers on a ward or private pavillion, can be startling to one not warned by sight of their approach. Most distressing of all are those sounds which cannot be interpreted. You can help your patient immeasura-

GOOD CHEER

FOR THE SICKROOM

SPRAY FRESHENOL

A PINEY PICK-UP FOR THE AIR

Makes the sickroom as pine-ily aromatic as a camp in Maine. Visitors are always welcome when Freshenol is handy. A bracing fragrance of pine forests and lavender makes the hospital room cheerful and pleasant for all. Sickroom odors vanish and so does your patient's embarrassment when you use this quick acting spray.

SPECIAL INTRODUCTORY OFFER TO NURSES

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We'll send you a *Freshenol* supply to last a long, long time, *plus a free 50c atomizer!* This special offer is good only until May 10th, positively. Print your name and address on the coupon and mail it to us now.

THE FRESHENOL COMPANY, Summit, New Jersey

Send me your $1.50 Freshenol Atomizer outfit for which I enclose one dollar.

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ALL MADE OF

Progar SlipKnot Poplin

—finest poplin ever tested by
Macy's Bureau of Standards!

Whether you want long sleeves or short sleeves; loose belts or set-in belts; buttons or slide-fasteners; V-necks or high necks—there's a Supre-Macy uniform for you! Sizes from 12 to 52. Sketched 10-gore swing skirt, style 500, with long or short sleeves, sizes 12 to 42. Mail and phone orders filled.

*Reg. U.S. Pat. Off.

Style 500

MACY'S NURSE HEADQUARTERS, U.S.A.

B'WAY AND 34TH ST., NEW YORK CITY

bly by keeping him posted on what goes on around him. A word or two from you when you enter his room puts him at ease too. He knows immediately that you are not a stranger before whom he must be on his guard.

There's one other point on which nurses can be extremely helpful. Try to encourage the sightless to use the word "blind" from the very beginning of their blindness. For some reason, the recently blind shy from the use of the one word which adequately describes their condition. It has peculiar associations—the blind beggar in the street; the lame, the halt, and the blind; blind as a bat; and innumerable others. Yet it need not have unpleasant connotations. You with your scientific knowledge and understanding of many human ailments can help your patient overcome his reluctance to use the word blind. It's important for him to do this. For until he does he is making life and normal conversation difficult for those who come in contact with him—and, incidentally, much more difficult for himself than it need be.

If you can do that, you will have made a notable contribution to the blind. You will have helped the blind patient develop an objective attitude toward himself. And unless he is able to do that he will be doomed to a life of hurts, misunderstandings, and unnecessary shadows.

[*Mrs. Bretz' book, "I Begin Again," was published in January by Whittlesey House.*—THE EDITORS]

R.N.'s BABY: Readers who wish to frame our January cover picture may have reprints without charge. Only a limited number are available and these will go to the first requests received. Please send along a three-cent stamp to cover postage. —THE EDITORS

Calling ALL NURSES

Is there someone in the profession you'd like to locate? You may insert here, without charge, a 75-word notice. Items will be published in the order received. Be sure to include your full name and address so that replies may reach you. Address the "Calling all nurses" editor.

ST. JOSEPH'S ALUMNAE: (Syracuse, N.Y.) On April 28th, 29th, and 30th we will hold a three-day reunion to celebrate our fortieth anniversary. The reunion will be opened with Mass in our chapel, followed by a Communion breakfast in the nurses' residence. The tea, traditional annual banquet, and graduation exercises should renew many old acquaintances. We hope to see as many alumnae as can attend. Anne Snyder, Publicity Chairman, St. Joseph's Hospital, Syracuse, N.Y.

WESSON MEMORIAL GRADUATES: (Springfield, Mass.) We wish to revise our mailing list, in preparation for the final graduation exercises and hospital reunion in May. Any graduate sending her correct address will receive more complete information about the meeting. Gertrude M. Lyons, Box 12, Hampden, Mass.

WICHITA HOSPITAL GRADUATES: We are having our second Homecoming in May. Any graduate sending her correct address will receive invitations containing complete information. Lillian Bedard Shanklin, 740 Ellis St., Wichita, Kan.

PHILADELPHIA MT. SINAI GRADUATES: May 8th has been set aside for our annual Alumnae Day. Please plan to attend and make it a grand reunion! Sara Kolin, 229 S. 22nd St., Philadelphia, Pa.

ST. JOSEPH'S GRADUATES: (Lancaster, Pa.) We would like to have a get-together for graduation this May. Please send ad-

dress for complete information. Anastasia Z. Keim, 250 N. 3rd St., Columbia, Pa.

CHAMBERLAIN SANITARIUM: Class of 1932. Several of our class want to start the class letter on the rounds again. I would like to have the addresses of the Misses Nelson, Holweger, Nehr, and Bland so that they may be included. Esther Wog-Swenson, New England, N. Dakota.

PHYLLIS SMITH JOHNSON: A graduate of Holy Cross Hospital in Salt Lake City. When last heard from she was in Portola, California. Anyone knowing her address please write to Marjorie Stuart Ellis, 540 O'Farrell St., San Francisco, Calif.

IRENE DASTAGUE WARD: Will anyone knowing the home address of this nurse or where she is working please let me know? When I last heard from her she was employed at Bellevue Hospital, New York City. Jennie E. Eveland, 8428 63rd Ave., Rego Park, L.I., New York.

ALL NURSES: My hobby is collecting "cats"—pictures, small figures, china, glass, wood, etc. All contributions gratefully received and postage paid. Pearl M. Baker, 4001 Woodland Ave., Philadelphia, Pa.

GERTRUDE PEEBLES HALL: Will you please write to me, as so many of the girls would like to hear from you. Ida Winter Clarke, 516 Independence Ave., Waterloo, Iowa.

LAURA BALDWIN: Does anyone know the present address of this nurse from North Carolina? When I last heard from her she was nursing at the Jewish Hospital, Brooklyn, N.Y. I would like to hear from her or about her. Kathryn J. Hinckley, 109 Brook St., Carbondale, Pa.

"DILLIE:" Where are you? A dear friend of yours wishes me to locate you. Remember the days we were in camp together? G. Langan, 2350 Fairview Ave., Cincinnati, O.

MINNIE ROSE GRIER: A graduate of St. Paul's Hospital of Nursing, Dallas, Texas. When I last heard from her she was in Los Angeles. Please write Bertha Jones

Watson, 522 E. 20th St., Cheyenne, Wyo.

SHELTERING ARMS HOSPITAL GRADUATES: (Hansford, W.Va.) I should like very much to hear from all of you. Marie M. Mullins, Box 342, Kingsport, Tenn.

Intestinal obstructions

[*Continued from page* 22]

cause of intestinal obstruction, however, is abdominal adhesions. Occurring any place in the abdominal cavity from a previous operation or peritonitis, these bands slowly constrict the small bowel. Intense abdominal pain and vomiting are produced when the obstruction becomes complete. Severe constipation is usually caused by this type of obstruction. Tenderness is greatest over the constricting adhesions.

Systemic effects of obstruction.—Nurses who have cared for patients with intestinal obstruction have undoubtedly been impressed by the attendant profound prostration. The cause of this moribund state are well defined.

The persistent vomiting leads to a great loss of fluids, with resulting dehydration. Even though no fluids are taken by mouth, about 7,000 c.c. of liquid can be lost in twenty-four hours through vomiting. (This amount is the quantity of digestive juices secreted daily into the upper intestinal tract.) The vomitus contains hydrochloric acid and sodium chloride from the gastric juice. The great loss of chlorides by this mechanism upsets the chemical composition of the blood even further. Moreover, the damaged bowel wall of strangulating lesions permits passage of toxic materials into the peritoneal cavity, leading to their systemic absorption. Marked alkalosis is also produced, adding further to the patient's weakened state.

In strangulating types of lesions, interference with the blood supply predisposes to hemorrhage into the bowel. In some cases, loss of blood by this route may be so severe as to produce

NEW EASY WAY TO AVOID THIS MESSY DUTY

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simply soak patients' FALSE TEETH clean and sweet with
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Never again need you vainly try to scrub tough mucin-film, tarnish and food debris from stained, slimy dentures. From now on, let POLIDENT do the dirty work.

POLIDENT—as thousands of nurses have discovered—simply *soaks* plates and removable bridges sweet, odorless, sparkling clean and pure. NO HANDLING! NO BRUSHING! HYGIENIC! All you do is place the denture in ½ a glass of water, add a little POLIDENT, let plate soak for 10 to 15 minutes, rinse—and *that's all!*

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Your patient, as well as yourself, will appreciate learning about POLIDENT. For POLIDENT *dissolves away* all traces of dingy film and discoloration . . . *soaks* out odors . . . leaves plates looking LIKE NEW. Its thorough cleaning action gets into every tiny crevice where brushing can't even reach. It won't harm dentures . . . is used and recommended by leading dentists everywhere.

WRITE FOR YOUR FREE SAMPLE—TODAY. Send name and address to Hudson Products, Inc., Dept. A1, 220 West 19th St., New York, N. Y.

WORKS LIKE MAGIC

Soak 10-15 minutes—Rinse—That's All!

Brushing false teeth is *dangerous* . . . as well as unpleasant. Polident minimizes danger of hand-infection from unclean plates . . . lessens possibility of scratching, dropping or otherwise damaging expensive dentures.

POLIDENT

the characteristic symptoms of hemorrhage.

Treatment and nursing care.—Two avenues of approach are needed for successful therapy: improvement of the general condition of the patient, and relief of the obstruction.

As soon as the diagnosis of mechanical obstruction has been made, the abdomen is opened. An attempt is made to find the seat of the pathology. However, if the condition of the patient is critical, an enterostomy is performed to permit the damned-up intestinal content to flow to the outside. Prompt surgery is especially important in cases of strangulating lesions. The objective is to restore the local blood supply before the bowel wall becomes irreparably damaged. In any event, surgical manipulation is held to a minimum.

Preparations should be made for giving saline solution by venoclysis or hypodermoclysis upon the patient's return to his room. A large quantity of fluid is usually required for several days or until fluids can be given by mouth. Dextrose is also administered to satisfy, at least in part, the caloric requirements.

If an enterostomy is performed, the drainage tube is connected to a bottle or some other suitable receptacle. The quantity of intestinal contents passed during each twenty-four-hour period should be noted. The alkaline drainage, containing active digestive enzymes, is irritating to the skin and may produce troublesome maceration. Application of sterile vaseline gauze dressings affords the necessary protection.

The quantity of urine voided is carefully measured, since the twenty-four-hour volume is the most accurate means of ascertaining the fluid requirements. The patient should be watched postoperatively for signs of increasing distention. Expulsion of gas or fecal material rectally indicates successful relief of the obstruction, and is a welcome prognostic sign. Persistence of vomiting is usually controlled by gastric lav-

age, hence a tray for this procedure should always be available.

If distention is not immediately relieved by the operation, two valuable therapeutic measures may be employed. Hot flaxseed poultices or turpentine stupes applied to the abdomen make the patient more comfortable and aid in encouraging expulsion of gas.

The second measure is continuous duodenal suction by means of the Wangensteen method. A Levin tube is passed into the stomach or duodenum. This tube is connected to a bottle which is joined with another bottle placed about 20 inches below the level of the bed. Water flows from the upper to the lower bottle, creating a partial suction in the former which sucks air and gas out of the upper intestinal tract. A conveniently located Y-tube permits aspiration of large particles which may clog the system.

Continuous suction is especially valuable in paralytic ileus. Large quantities of fluid are removed from the stomach, maintaining a state of continuous decompression. The necessity for vomiting is obviated, and the stomach quickly returns to normal size. Since the indwelling nasal tube is employed in this technique, the patient is spared the discomfort incident to frequent passage of a stomach tube. The suction apparatus may be turned on and off at will; intermittent action can be obtained if needed. As the intestinal tract approaches a state of normal function, small quantities of fluids may be given by mouth to test the patient's tolerance.

Continuous suction is advantageously employed postoperatively in mechanical ileus. The frequency of vomiting is markedly lowered, reducing the strain on the abdominal wall incision. Return of normal gastrointestinal function is thus hastened.

The Wangensteen technique is used by many surgeons as a prophylactic measure in major abdominal surgery when postoperative vomiting or distention

must be avoided. It is also of great value in patients with neglected intestinal obstruction who are poor surgical risks. In many cases, twelve-hours of duodenal drainage ameliorates the condition of the patient to the point where surgery can be undertaken.

[*Send a stamped, addressed envelope for a bibliography of the procedures discussed in this article.*—THE EDITORS]

Accent on spring

[*Continued from page* 19]

nurses they will offer a starchless poplin which will be especially adaptable to the new silhouette. Other materials which capture the eye for Spring and Summer are rayon alpaca, broadcloth, silk shantung, seersucker, and sharkskin.

Several manufacturers are featuring sharkskin this year to the exclusion of all other fabrics. They believe its unusual whiteness makes it especially logical for nurses' uniforms. For coolness and chic, too, they predict its swift rise. (Laundering experts, however, warn that sharkskin should not be trusted to the hospital laundry. Lukewarm suds and a moderate iron applied to the wrong side is the approved method—and you can easily do this yourself.)

In sharkskin, as in other materials, you get what you pay for. Cheap sharkskin will bring you grief with raveled buttonholes and torn seams. Pay between $3 and $4 for your uniform and you should get quality fabric, designers advise. Details like fine finish on seam and hem are your guides to good workmanship.

Poplins this season are sturdier than ever—a designing feat, since each new fabric is soft and easily molded to the figure.

Recent reports from the Better Fabrics Testing Bureau show that the four

leading brands of poplins resisted, respectively, 2,000 to 4,000 "double rubs"—the Bureau's term for its most severe abrasive test on fabric wearability. Few nurses would ever expose their uniforms to the harsh abrasive used in the Bureau's test. It would be something like rubbing your uniform sleeve over a rough surface 4,000 times in one direction and 4,000 times in another. That should give you some idea of the wearability of the newer poplins.

In the accompanying illustrations you will find several of the fashion features which distinguish this year's crop of uniforms from those of previous years. Here are some specific accents to look for:

The built-out shoulder, giving the inverted triangle effect to the entire silhouette.

The long torso and nipped-in waist line.

Flared skirts with good-sized hems.

Unusual treatment of gores and fine tucking.

Short sleeves.

Unusual pocket treatment.

Pockets are a Paris fashion feature this year and, happily, nothing could suit the nurse better. Current styles show enormous patch pockets—no longer disguised—which follow the basic lines of the uniform and allow room for all your nursing accessories. Other pockets run at acute angles to the side seams; some are inverted, revealing only the opening slit into the fullness of the skirt. Still others are frankly used for decoration on bodice and skirt.

As a special feature this year, most manufacturers are solving the periodic sleeve problem by offering all popular styles with both long and short sleeves.

Skirt lengths are shorter, too. They give the effect of greater length, however, through the fullness of the skirt and the long torso lines.

Fortunately, prices remain at their usual low levels. If you have from $3 to $6 to spend there is no limit to the

variety of styles and fabrics from which you can choose. Manufacturers recommend, however, that for the warm weather a practical and economical trick is to buy several light-weight, short-sleeved uniforms in typical Summer fabrics, at typical Summer prices —around $3. This permits you to expand your work wardrobe without adding extra expense.

Who is really the stylist for uniforms? The nurse herself, say manufacturers. "We will give you whatever you demand. Your standards are our rule-book."

"One thing is certain," said a prominent designer when showing his Spring catalog. "Nurses are taking a new interest in their work clothes . . . The uniform is not so 'uniform' this year."

[*A list of uniform manufacturers who have catalogs available for distribution will be sent on receipt of a stamped, addressed envelope.*—THE EDITORS]

"Dear Mrs. Brande—"

[*Continued from page* 15]

one common lump to which one set of rules applies.

You, Mrs. Brande, like your face washed with tepid water. Mrs. Williams? Indeed not! Her face never feels really clean unless it's washed with good *hot* water. Mrs. Perkins likes an ice-cold cloth. She never says so, of course. We have to discover her tastes, sometimes by the tedious trial-and-error method. Because most patients—whether from fatigue, shyness, or physical discomfort —just cannot state their preferences simply, as would a healthy person. You yourself have said, "*Please* don't ask us to make decisions."

I don't remember ever admiring myself particularly in the "sweetness and light" role. Still, there were times when I played it for all it was worth and it worked like a charm. [*Turn the page*]

ACTION Below The Surface in Local Congestion

Below the skin, that's where MINIT-RUB exerts its stimulating action. Counterirritation stirs local circulation for capillary dilation. Improved lymph and cell activity help dispose of congestion waste. Local analgesia quickly comforts irritated nerves and muscles. MINIT-RUB refreshing relief is indicated in . . .

Sore, aching, strained muscles — local congestion of uncomplicated colds — simple neuralgias — head colds — upper respiratory tract chest colds.

MINIT-RUB is clean, convenient, economical . . . Its action is prompt and prolonged. Rub a bit into your hands and feel its effects.

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Send a generous trial tube of MINIT-RUB to . . .

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Street & No.....

City.....State.....

When you come right down to it, we have to be all things to all people. Perfection for one patient might be poison for another. So, if we happen to miss one case out of a hundred, don't hold it against us. When you do, it sounds (to use your own words) "too incredibly petty."

Tuberculosis

[*Continued from page* 10]

A second faction thinks that the State nursing associations should legislate for compensation laws to provide funds for the incapacitated.

A third holds that the State societies should run clearance bureaus to route tuberculous members through existing facilities.

A fourth wants the State associations to wage an educational campaign to make hospitals—and particularly their lay boards—see the necessity of contagious techniques. Since the latter have been advocated largely by doctors, many within this group favor seeking the cooperation of medical societies.

A considerable number of nurses have no preferences among these approaches. They believe that *all* should be included in any drive for an improvement of existing conditions. What is most needed, they emphasize, is *integrated action.* And they uphold Dr. Emerson's thesis that "the logical center of this action should be the American Nurses' Association through its affiliated State associations."

Up to now, the A.N.A. has been slow to act on this matter. Its one move—abolition of its national relief fund in 1932—is regarded in most quarters as a backward step.

At the time, the reasons given for dropping the fund were: (1) That most relief candidates after 1920 had tuberculosis; (2) that prevention, rather than "cures," must be stressed; (3)

LABORATORY TEST REPRINTS—Reprints of the resume of commonly employed laboratory tests, which was published in July, are now available. You may have your copy by simply sending a stamped, self-addressed envelope. If you wish more than one copy, send five cents for each additional reprint wanted.

R.N.—A JOURNAL FOR NURSES
RUTHERFORD, N.J.

that its leaders had faith in "self-help."

Today many nurses are strongly critical of this explanation. That the majority of nurses requesting aid should have been tuberculous, they say, is an indication of where the need lies. That prevention should be stressed, they observe, is a good rule—if the A.N.A. would only follow it. That "self-help" is a fine ideal, they don't doubt, if tuberculous nurses were only in a better position to help themselves.

In view of these facts, it is easy to see why the rank-and-file of nursing wish for a more down-to-earth stand on T.B. by their professional association. Until this is forthcoming, they fear a lot more young nurses may have to die.

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What is your "I.Q." on new products and services? Here is a ready check-list to keep you up-to-date. You may have samples or literature by writing the manufacturers whose products are described on this page. Be sure to give your registration number, however. The service is available only to registered nurses.

HAND CREAM: Of course you want to check the toll that scrubbings take in hand appearance . . . But how? PACQUIN'S hand cream was originally developed by the manufacturers to meet nurses' needs. It is said to be effective for keeping hands smooth looking; will not leave a sticky film. R.N.'s may have a free trial jar by writing to Pacquin, Inc. Dept. RN 4-40, 101 West 31st St., New York, N.Y.

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LANOLIN SOAP: Skin irritation due to dryness and chafing is often a sickroom problem. As a corrective, many dermatologists recommend pure lanolin or products with high lanolin content. BOTANY lanolin superfatted soap is rich with lanolin. Its makers say it has been used successfully on infants as well as adults; the animal fats which it contains, in fact, tend to neutralize alkali and to soothe and soften the skin. If you would like to try this soap yourself, write to Dept. RN 4-40, Botany Worsted Mills. Passaic, N.J.

COSMETIC-TWINS: The makers of SITROUX cleansing tissues now offer two brand new face creams. One is a cleansing and lubricating cream made, according to the manufacturers, from purest oils. The other is a light finishing cream suitable for use as a powder base. Although both creams are economically priced, they are said to contain carefully-selected ingredients—no stearic acid or beeswax. Generous samples of the two creams will be sent readers who request them. Dept. RN 4-40, The Sitroux Co., Inc., 468 Fourth Ave., New York, N.Y.

SLEEP-AID: Have trouble sleeping in the daytime when you are on night duty? SLEEP SHADE is a medically-approved eye mask which shuts out light. Nurses who have used it say it helps them to sound refreshing sleep any hour of the day. The shade weighs less than half an ounce. Adjustable elastics hold it firmly in place without pressure. See special offer on page 28, or write for free illustrated folder. Dept. RN 4-40, Sleep Shade Corp., 425 Bush St., San Francisco, Calif.

Classified

There is no charge to registered nurses for the use of this department. To apply for a "position available," simply outline your qualifications in a letter. Address the letter to the correct box number care of R.N.—A JOURNAL FOR NURSES, *Rutherford, N. J. (Send no money with your application. If the bureau requires a registration fee, it will bill you separately.)*

POSITIONS AVAILABLE

***ADMINISTRATOR:** Experienced and well-educated graduate nurse to take charge of 90-bed hospital; privately operated, well equipped, endowed. All-graduate staff. Outstanding woman required. (Placement bureau charges $2 registration fee.) Box MB 4-1.

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**Position listed by a placement bureau.*

orange-growing section. Salary $80; maintenance. (Placement bureau charges no registration fee.) Box W150.

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*INSTRUCTOR, SCIENCE: South. College degree required for position in training school averaging 50 students. (Placement bureau charges $2 registration fee.) Box C105.

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*OFFICE NURSE: Southeast. Should be laboratory technician and able to assist with X ray. Large practice. Salary open. (Placement bureau charges $2 registration fee.) Box C100.

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*SUPERVISOR: South Carolina. For position in communicable diseases department of fairly large hospital. (Placement bureau charges $2 registration fee.) Box MB 4-17.

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*SUPERVISOR, GYN. WARD: For position in large teaching hospital. (Placement bureau charges $2 registration fee.) Box MB 4-19.

*SUPERVISOR, MEDICAL: East. To take charge of 30-bed floor; adequate number of assistants. New hospital pleasantly located short distance from Atlantic Ocean. (Placement bureau charges $2 registration fee.) Box MB 4-20.

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*SUPERVISOR, MEDICAL-SURGICAL: California. College degree required; must be capable of teaching student nurses on ward. Private hospital, seaside city. (Placement bureau charges no registration fee.) Box W155.

*SUPERVISOR, NIGHT: Michigan. Catholic preferred for position in progressive hospital. Experience desirable. Salary $110; board. (Placement bureau charges $2 registration fee.) Box C996.

*SUPERVISORS, NIGHT: Pacific Coast. Several openings in California and Washington hospitals. Salary $90-110; maintenance. (Placement bureau charges no registration fee.) Box W156.

[*Turn the page*]

*Position listed by a placement bureau.

***SUPERVISOR, OBSTETRICAL:** California. Thoroughly qualified woman required for position in department averaging 35 patients in fairly large hospital. (Placement bureau charges $2 registration fee.) Box MB 4-22.

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***SUPERVISOR, OPERATING ROOM:** Thoroughly qualified woman with considerable ability, dignity, and personality required for position in large teaching hospital. (Placement bureau charges $2 registration fee.) Box MB 4-23.

***SUPERVISOR, ORTHOPEDIC:** For position in large teaching hospital; to succeed woman who has held position 10 years. (Placement bureau charges $2 registration fee.) Box MB 4-25.

***SUPERVISOR, PEDIATRIC:** East. Position in teaching hospital. (Placement bureau charges $2 registration fee.) Box MB 4-26.

***SUPERVISOR, PEDIATRICS:** California. Postgraduate training, experience as charge nurse required. Some college training preferred. Institution one of most progressive in State. Salary $125; meals. (Placement bureau charges no registration fee.) Box W156.

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***SUPERVISOR, SURGERY:** California. Full charge of department in large, approved, county institution. Salary $110; maintenance. (Placement bureau charges no registration fee.) Box W159.

***SUPERVISOR, SURGERY:** California. Post-graduate course or experience as charge nurse in busy surgery required for position in privately owned industrial and emergency hospital. Salary $125; meals. (Placement bureau charges no registration fee.) Box W157.

***SUPERVISOR, SURGICAL:** Hawaii. Three years' experience in supervising chest surgery required for position in fairly large hospital with considerable chest surgery. Adequate number of assistants. (Placement bureau charges $2 registration fee.) Box MB 4-27.

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***SURGICAL NURSES:** California. Two positions in beautiful, privately owned hospital. (Placement bureau charges $2 registration fee.) Box MB 4-29.

***TECHNICIAN:** Florida. Graduate nurse, qualified in X-ray and laboratory work, required for position in small hospital in winter resort town. (Placement bureau charges $2 registration fee.) Box MB 4-30.

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***TECHNICIAN NURSE:** Southwest. Graduate nurse, trained in routine laboratory and X-ray work. Salary $90; maintenance. (Placement bureau charges no registration fee.) Box W158.

VITAMIN B_6

A RECENTLY IDENTIFIED COMPONENT OF THE VITAMIN B COMPLEX

• During the past few years, brilliant research made possible the resolution of the vitamin B complex into various components, including thiamin, riboflavin and nicotinic acid (P-P factor). The essential characters of these factors in human nutrition are, of course, clearly recognized. Within the past two years another component of the complex, namely, vitamin B_6, has been identified. At the present time, it appears very probable that this vitamin is also necessary for the human.

Vitamin B_6 has been designated biologically as, "that part of the vitamin B complex which is responsible for the cure of a specific dermatitis developed by young rats on the vitamin-free diet supplemented with Vitamin B_6 and lactoflavin" (1). The isolation in crystalline form, chemical identification and synthesis of vitamin B_6 have already been accomplished (2, 3). Chemically, vitamin B_6 is 2-methyl, 3-hydroxy, 4, 5-dihydroxymethyl pyridine. The free base melts at 160°C. and is apparently stable at elevated temperatures.

A recent medical report (4) suggests that vitamin B_6 may be an essential component of the human diet. In one small group of persons it was observed that certain neurological symptoms, which did not respond to treatment with nicotinic acid, riboflavin and thiamin, were distinctly alleviated by the administration of pure synthetic vitamin B_6. This observation is strongly indicative of the importance of vitamin B_6 in human nutrition, and further emphasizes the importance of a varied diet for supplying all nutrients required by the human being.

The distribution of vitamin B_6 in food products has not as yet been extensively investigated. However, vitamin B_6 activity has been observed in a variety of natural food materials (5). Hence, it appears that we should continue to rely upon a varied diet to supply our requirements for all components of the vitamin B complex, vitamin B_6 included. The high heat stability of this new vitamin suggests that many foods which commercial canning makes readily available during all seasons of the year may prove to be valuable sources of vitamin B_6, whose essential character in human nutrition seems strongly indicated at this time.

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(1) 1939. The Vitamins, pages 127-140, American Medical Assn., Chicago.

(2) a. 1938. Proc. Soc. Exptl. Biol. Med. 38, 64.
b. 1938. J. Am. Chem. Soc. 60, 1267.
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(3) 1939. J. Am. Chem. Soc. 61, 1245.

(4) 1939. Am. Med. Assoc. 112, 2414.

(5) a. 1936. Missouri Agric. Expt. Sta. Research Bull. No. 241.
b. 1938. Biochem. J. 32, 708.
c. 1938. Indian. J. Med. Res. 25, 879.

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